U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 28 February 2006

In the Matter of:

ROGER L. NEWBERRY,
Claimant

v.

G & A COAL COMPANY,
Employer

and

ZURICH AMERICAN INSURANCE GROUP,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No.: 2003-BLA-3

Appearances:

Sparkle Bonds, Lay Representative
Virginia Black Lung Association
Richlands, VA
For the Claimant

Charles Midkiff, Esq.
Midkiff, Muncie & Ross, P.C.
Richmond, VA
For the Employer

Susan Brenner, Esq.
Office of the Solicitor
Arlington, VA
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Roger L. Newberry, alleges that he is totally disabled by pneumoconiosis.

There was no hearing on this case, as all parties agreed to have the case decided on the record. In an order dated May 12, 2004, I admitted Director's Exhibits ("DX") 1-37, Claimant's Exhibits ("CX") 1-6, and Employer's Exhibits ("EX") 1-55 into evidence and set a schedule to complete the record. The Claimant's exhibits were admitted over the Employer's objection that they were untimely, as I found them to be timely. Employer's Exhibit 56 was excluded as untimely. Closing arguments were due to be filed by August 11, 2004. The Employer objected to the possible late filing of the Claimant's closing argument, which was dated August 6, 2004, but not received until August 19. As the Employer has shown no prejudice by late receipt of the Claimant's argument, I hereby overrule the objection.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his claim on September 22, 2000. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on January 22, 2001, on the grounds that the evidence did not show that the Claimant was totally disabled. The Claimant did not appeal that determination. Rather, less than one year later, on January 4, 2002, the Claimant filed a request for modification. DX 19. The request for modification was granted by the District Director on May 17, 2002. The Director found that new x-ray and CT scan evidence demonstrated complicated pneumoconiosis. DX 30. The Employer requested a formal hearing on August 1, 2002. DX 32. The claim was referred to the Office of Administrative Law Judges for hearing on October 2, 2002. DX 37. Thereafter, the parties agreed to a decision on the record.

APPLICABLE STANDARDS

This case pertains to a request for modification of an adverse decision on a claim filed on September 22, 2000. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2005). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that

as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2005). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2005). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). In this case, the Claimant filed his claim before the effective date of the new regulations. Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2005 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that he is entitled to benefits, the Claimant must demonstrate that there has been a change in conditions or a mistake in determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 , 718.204, and 725.103 (2005). Where modification is sought based on an alleged change in conditions, new evidence must be submitted and the administrative law judge must conduct an independent assessment of the newly submitted evidence, in conjunction with the evidence previously submitted, to determine whether the weight of the evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 BLR 1-111, 1-113 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156, 1-158 (1990), *modified on recon.*, 16 BLR 1-71 (1992). Where modification is sought based upon a mistake of fact, new evidence is not a prerequisite, and the adjudicator may resolve the issue based upon "wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971); *Kovac v. BCNR Mining Shipyards, Inc.*, 16 BLR 1-71, 1-73 (1992), *modifying* 14 BLR 1-156 (1990).

ISSUES

The issues contested by the Employer are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. The number of his dependents for purposes of augmentation.

DX37.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Newberry was deposed on March 31, 2003. EX 48. He lives with his wife and son, then 17. *See* DX 7; DX 8. He also has a married daughter. Thus at the time of his deposition he had two dependents for the purpose of augmenting any benefits to which he may be entitled. He has a third grade education, and said a friend helped him write letters to the Department of Labor in pursuing his claim. He receives Social Security disability benefits related to his heart condition and lungs.

Mr. Newberry had a heart attack in 1998. He was treated for three days at Humana Clinch Valley, where he had a cardiac catheterization and was put on medicine. He was off work for about three weeks, and then went back to work at his original job. He worked until the mine closed in January 2000. That was his only hospitalization since 1993.

Although medical records indicate that he was still smoking as recently as March 2000, he testified that he quit smoking when he had his heart attack. He said he smoked a pack or less per day from the age of 22. He did not recall having been told he had emphysema, or having told his doctor that he had received benefits for silicosis, but he did recall receiving a settlement for stage one rock dust under state law. Documentation from the state settlement is in the record at EX 47. The copies are poor, and many of the documents are blurred and illegible, or only partly legible. Test results which can be deciphered appear on the charts below. Mr. Newberry said he never worked around asbestos.

His treating physicians are Dr. Piriz, for his heart, and Dr. Iosif, for his lungs. Dr. Piriz restricted his walking. According to Mr. Newberry, Dr. Piriz recommended that he go back to work after his heart attack, but the longer he worked, the worse he got, so he went to see Dr. McVey (who also treated him when he had his heart attack), who referred him to Dr. Iosif, who said he was disabled based on his lungs. Dr. Iosif prescribed oxygen for eight to ten hours a day, as well as inhalers.

During his mining career, he worked as a continuous miner operator, driller and shooter, miner helper and car dropper. At G& A Coal Company, he was a continuous miner operator, always underground. His last coal mine employment was in Virginia. DX 2. Therefore this

claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this request for modification.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column. In addition, some x-rays were found by some readers to be unreadable due to poor quality. Those have also been listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), or the registry of physicians' specialties maintained by the American Board of Medical Specialties. [1] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/15/77		EX 1 Sutherland Clinic X-Ray Report, 0/1	
05/08/80	CX 3, EX 2 Eryilmaz A/BCR UICC category 1:0 "Minimal pneumoconiosis"		
05/23/82			CX 3 Patel A/BCR Mild to moderate degree of emphysematous changes
03/11/85			CX 3 Patel A/BCR Mild to moderate emphysematous changes.
10/30/85	EX 3, EX 47 Bassali, B/BCR ILO Classification 1/1 EX 5, EX 47 Fisher, B/BCR ILO Classification 1/2 EX 6 Penman ILO Classification 1/2 EX 7 Aycoth, B/BCR ILO Classification 2/1 EX 8 Mountain State Radiology ILO Classification 2/1	EX 47 Unknown EX 47 Scott, B/BCR	EX 47 Wheeler, B/BCR Illegible

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/12/92			CX 3 Patel A/BCR Emphysema with chronic interstitial disease. Nodular densities more obvious compared to prior examination
04/09/97			CX 3 Patel A/BCR Chronic interstitial lung disease
10/29/97			CX 3 Patel A/BCR Chronic interstitial lung disease
04/19/98		DX 29, DX 31, EX 9 Wheeler, B/BCR DX 29, DX 31, EX 10 Scott , B/BCR	EX 11, EX 43 Fino B Unreadable copy EX 30 Naik Lungs clear. No acute abnormality.
02/23/00			CX 3, DX 32 Patel A/BCR Chronic interstitial lung disease. DX 34 Iosif A Poor quality films; possible fibrotic conglomeration DX 29, DX31, EX 12 Wheeler, B/BCR Unreadable DX 29, DX31, EX 13 Scott, B/BCR Unreadable
10/20/00	DX 12, EX 14 Ramakrishnan, B/BCR ILO Classification 2/2 DX 14, EX 15 Navani B/BCR ILO Classification 1/1		

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/23/00	DX 15, EX 16 Navani, B/BCR ILO Classification 1/1		
11/13/01	DX 27 Fleming No ILO classification. "Pneumoconiosis more pronounced today than on 04/19/98." CX 1, DX 20 Alexander, B/BCR ILO Classification 2/2. Large opacities B DX 25, EX 54 Navani, B/BCR ILO Classification 1/2	DX 29, DX 31, EX 17 Wheeler, B/BCR DX 29, DX 31, EX 18 Scott, B/BCR	EX 19, EX 43 Fino, B Unreadable copy
12/13/01	DX 26. EX 55 Navani, B/BCR ILO Classification 2/1		
03/06/02	DX 28, DX 31, EX 2, EX 42 Castle, B ILO Classification 2/2; Large Opacities B CX 4 Alexander, B/BCR ILO Classification 2/2 Large Opacities B CX 5 DePonte B/BCR ILO Classification 2/2 Large Opacities B	EX 23/EX 43 Fino, B ILO Classification 0/0 EX 21 Wheeler, B/BCR EX 22 Scott, B/BCR	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). Mr. Newberry's medical records indicate that he has undergone three CT scans of his chest, on March 23,2000, October 23, 2000, and December 13, 2001. The record contains the radiologist's report for the later two scans, but not the first. In addition to the initial reports of

the later two scans, the record also contains readings by two additional radiologists who interpreted the December 13, 2001, CT scan for the Claimant. The radiologists' interpretations are set forth in this section of the decision. Both pulmonologists who gave opinions on the claim (Dr. Iosif and Dr. Castle) had access to all three CT scans. Their interpretations are described below in the section on medical opinions.

The second CT scan was performed on October 23, 2000, by Dr. Ramakrishnan, a Board certified radiologist and B reader, who reported the following as his impression:

> Small nodular opacities of the lungs in the upper and mid lung zones with coalesces of the nodules in the subpleural location in the mid lung zones on both sides. No significant plaques or calcifications of the pleura could be seen. Small calcified lymph nodes of the hila are also noted. Although somewhat atypical due to the subpleural distribution of the nodules, these findings may represent pneumoconiosis with some complications due to coalesis of nodules. Differential possibility of changes due to asbestos exposure cannot be completely excluded, although these findings are not typical of asbestos lung changes either. Overall, the findings are unchanged from March 2000. Please correlate with the occupational history.

DX 13; EX 38.

Dr. Ramakrishnan also performed the third CT scan on December 13, 2001. DX 27; CX 2. Dr. Ramakrishnan gave the following impression:

> Interstitial fibrosis with nodules predominantly in the mid lung zones with coalescence of the nodules in the subpleural location of the mid lung zones are noted. The appearance of lesions and the extent of the interstitial process is basically unchanged from previous examination of October 2000. Differential diagnosis of the findings were discussed on the report of the CT scan of October 2000.

DX 27; CX 2.

Dr. Michael Alexander, a Board certified radiologist and B reader, also interpreted the December 13, 2001 CT scan. DX 20; CX 1. Dr. Alexander found that "[m]ultiple bilateral primarily pleural based conglomerate masses are present in the upper and mid lung zones seen against a background of small round opacities, diagnostic of complicated Coal Workers Pneumoconiosis." DX 20; CX 1.

Finally, Dr. Kathleen DePonte, a Board certified radiologist, also read the December 13, 2001, CT scan. CX 6. Dr. DePonte drew the following conclusions:

1. Nodular interstitial lung disease in a pattern consistent with coal workers' pneumoconiosis and silicosis with progressive massive fibrosis (complicated coal workers' pneumoconiosis.)

2. Emphysema.

CX 6.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[2]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 3 10/09/92 McVey	48 69"	3.52	4.18	84.3%		No	Pulmonary function good

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 68" to 69", I have taken the mid-point (68.5") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the mid-point, or the heights listed by the persons who administered the testing.

Ex. No. Date Physician	Age Height[2]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 24 03/17/00 Iosif	54 69”	3.24 3.37	4.15 4.35	78% 77%	124	No	Normal. Good effort Good cooperation. Normal volumes and diffusion capacity.
EX 25 07/07/00 Iosif	55 68”	3.28 3.36	4.45 4.53	73.7% 74.1%		No	Normal. No notation of cooperation or comprehension.
DX 11 10/20/00 Iosif	55 68”	3.28	4.30	76.3%		No	Excellent effort and cooperation. Normal.
DX 28 DX 31 EX 26 EX 42 03/06/02 Castle	56 68”	2.83 3.04	3.92 3.98	72% 76%	88	No	Normal. No evidence of obstruction or restriction. Normal diffusing capacity.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this request for modification. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
CX 3, EX 27	02/23/00	McVey	39.2	70.3	No	
EX 28, DX 11	10/20/00	Iosif	40.7	73.8	No	
DX 28, DX 31 EX 29 EX 42	03/06/02	Castle	37.9	75.1	No	Normal.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record in this case contains treatment records from Dr. James McVey, Dr. Jose Piriz, and Dr. German Iosif, and opinions given in connection with the claim from Dr. Iosif, Dr. John Michos and Dr. James Castle.

Dr. McVey wrote a letter dated February 25, 2003, stating that Mr. Newberry had been his patient since March 11, 1975, last seen on October 15, 2001, and that Mr. Newberry had never been treated for pneumonia. Attached to the letter were intermittent progress records from Dr. McVey for the period between 1976 and 2001, along with chest x-ray reports, a pulmonary function test from 1992, and an arterial blood gas study from 2000, the results of which appear on the charts above. Between 1976 and 1998, the chart reveals occasional references to upper respiratory tract infections, chronic obstructive pulmonary disease (COPD) and bronchitis. Dr.

McVey urged Mr. Newberry to stop smoking, and to wear a mask in the mines, as he was at high risk for lung disease. CX 3.

Treatment records from Clinch Valley Medical Center show that Mr. Newberry was admitted to the hospital on April 19, 1998 with chest pains. EX 30; EX 45. During a chest examination, Dr. McVey found Mr. Newberry's lungs were "clear, but … decreased breath sounds throughout.… no wheezes or rales." In his hospital progress notes dated April 22, 1998, Dr. McVey noted that Mr. Newberry had had a myocardial infarction which had been controlled, and also assessed COPD (chronic obstructive pulmonary disease). Dr. McVey consulted with Dr. Piriz during Mr. Newberry's hospital stay, and both physicians followed him after his release.[3] Echocardiogram was normal. According to Dr. Piriz, cardiac catheterization showed:

1. Nonocclusive single-vessel coronary artery disease of the left anterior descending artery.

2. Small nondominant diffusely diseased right coronary artery with several severe obstructions noted throughout the entire course.

3. Normal left ventricular size and function.

4. No segmental wall motion abnormalities visualized.

EX 45. Mr. Newberry was discharged on April 24, 1998, with a final diagnosis of "post acute anterior myocardial infarction." EX 30. The discharge summary noted that Mr. Newberry had "a history of chronic obstructive pulmonary disease and severe cigarette abuse." EX 45. Dr. Piriz cleared Mr. Newberry to return to work in May 1998. At that time, Dr. Piriz' impression was status post aborted anterior wall myocardial infarction, and nonocclusive coronary artery disease. EX 50.

Following Dr. Piriz' progress note from May 1998, there is an almost two-year gap in the medical evidence. The next available medical record is an outpatient progress record from Washington Square Clinic dated February 14, 2000. Mr. Newberry went to the clinic complaining of shortness of breath and sore lungs. This record noted that "[h]is breath sounds were decreased. He seems to have a barrel chest." In addition to coronary artery disease, status post myocardial infarction, Dr. McVey assessed Mr. Newberry as having COPD exacerbation and cigarette abuse, long standing. Dr. McVey referred Mr. Newberry for a stress cardiolite study, and noted, "[i]t is felt this patient is probably totally and permanently disabled for gainful employment." Finally, Dr. McVey observed that he "[m]ay also need pulmonary referral." CX 3; EX 31.

Mr. Newberry returned to the Washington Square Clinic on February 23, 2000. Dr. McVey noted that Mr. Newberry had severe dyspnea on exertion. Mr. Newberry was assessed with pulmonary fibrosis, emphysema and severe cigarette abuse. Dr. McVey planned to refer Mr. Newberry to Dr. Iosif "because of shortness of breath and inability to work, and dyspnea on

[3] Dr. McVey's and Dr. Piriz' qualifications are not in the record; nor is either listed on the web-site maintained by the American Board of Medical Specialties.

exertion." Dr. McVey advised Mr. Newberry to get his weight down and stop smoking. This report included a x-ray report, which noted that "[s]lightly hyperinflated lungs with prominent bronchovascular markings in the form of reticulo-nodular densities involving both lungs indicate chronic interstitial lung disease." This x-ray was compared with a prior study of 1997, noting that "there [are] no obvious interval changes." CX 3; EX 32.

Dr. McVey referred Mr. Newberry to Dr. Iosif, who is board-certified in internal medicine and pulmonary disease, DX 27, to conduct a pulmonary evaluation. Dr. Iosif reported the results to Dr. McVey in a letter dated March 3, 2000. EX 33. He took occupational, social, family and medical histories, and conducted a physical examination. He reported that Mr. Newberry worked in the mines for 30 years. He said Mr. Newberry had developed "slowly progressive exertional dyspnea for the last several years." He reported that Mr. Newberry "has been a smoker from teenager but states that his daily cigarette consumption has been reduced to maybe half a pack a day in recent months." The chest examination was normal except for some slight hyperinflation. Additionally, Dr. Iosif reviewed chest x-rays taken in April, 1998. He stated that the findings from these x-rays were "consistent with chronic and stable reticulonodular interstitial opacities suggesting simple CWP [coal workers' pneumoconiosis]." Dr. Iosif diagnosed simple coal workers' pneumoconiosis with a "suspicion of associated COPD from long-standing history of cigarette smoking." He also suspected obstructive sleep apnea. At that time, Dr. Iosif made no findings as to whether Mr. Newberry was disabled due to pneumoconiosis. He planned to refer Mr. Newberry for full pulmonary function testing, and to have him complete a sleep questionnaire and try to stop smoking

Dr. Iosif saw Mr. Newberry in follow-up on March 17, 2000. Mr. Newberry told Dr. Iosif he had cut back his smoking to one pack per day. During this visit, a full pulmonary function test was conducted, and the results were "fairly good." Pulmonary auscultation was clear. Dr. Iosif reviewed chest films from February 23. He considered them to be of poor quality, but saw "the possible presence of fibrotic conglomeration in the periphery of the mid and upper lung zones. Dr. Iosif assessed Mr. Newberry with, among other things, "Silicosis/coal workers' pneumoconiosis with possibility of complicated disease," nocturnal snoring and nicotine addiction. Dr. Iosif referred Mr. Newberry for a high resolution CT of the chest. He further stated, "The presence of large interstitial opacities could automatically qualify him for black lung benefits under the Federal Standards. This could also serve as a baseline for future comparison, given the existence of cigarette smoking, family history of lung cancer, etc." Dr. Iosif also ordered nocturnal pulse oximetry and other measures to attempt to reduce Mr. Newberry's snoring. EX 34.

At a follow-up visit on April 28, 2000, Dr. Iosif reported that Mr. Newberry came in complaining about exertional dyspnea with diminishing endurance. He had stopped smoking. Dr. Iosif reviewed the results of the March 23, 2000, CT scan. He stated that "there are findings consistent with CWP with larger pleural based masses located in the upper lung zones bilaterally." Overnight pulse oximetry measured March 29 showed intermittent mild nocturnal hypoxemia. Dr. Iosif found that Mr. Newberry's lungs were clear. Dr. Iosif's diagnoses included "CWP with question of associated old granulomatous disease," nocturnal hypoxemia, for which oxygen was prescribed, and coronary artery disease. He went on to state, "Given the normalcy of the pulmonary function test, [Mr. Newberry's] exertional dyspnea could be due to

deconditioning, although cardiac ischemic involvement cannot be ruled out. Dr. Iosif planned to refer Mr. Newberry for a cardiology evaluation, schedule blood tests, continue regular follow-up with Dr. McVey, and recommended attendance at a wellness center. EX 35.

Dr. Piriz performed a second cardiac catheterization in May 2000. He found:

1. Significant three vessel coronary artery disease with 100% occlusion of the right coronary artery; 50% obstructions of the circumflex and left anterior descending coronary artery are also noted in their mid portions.

2. Normal left ventriculogram with normal left ventricular size and overall systolic function.

EX 36, EX 46. At a follow-up visit in June 2000, Dr. Piriz recorded that Mr. Newberry was feeling well and had no particular complaints or new symptoms "other than continues the dyspnea on exertion." Dr. Piriz recommended that current medical management of Mr. Newberry's condition be continued, as the obstructions were not significant enough to warrant an invasive procedure. EX 51.

Mr. Newberry returned to Dr. Iosif on July 7, 2000. Dr. Iosif noted that the cardiac catheterization had taken place, with no changes in medication thereafter. Mr. Newberry reported that he was using oxygen at night as directed. Pulmonary auscultation showed preserved breath sounds throughout. Spirometry was normal despite complaints of dyspnea on exertion. Dr. Iosif's assessment included "Nocturnal hypoxemia/CWP and old granulomatous disease." EX 37.

Dr. Iosif examined Mr. Newberry on behalf of the Department of Labor on October 10, 2000. DX 10. He noted Mr. Newberry's occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Newberry worked in the mines for 30 years. He reported a smoking history of one pack of cigarettes a day from his teens until April 2000. The chest examination was normal. Chest x-ray showed "a profusion score of 2/2 and indication of confluence." The pulmonary function test was normal. The arterial blood gas study was also normal. Because of Mr. Newberry's smoking history, Dr. Iosif referred him for another high-resolution CT scan of the lungs. Dr. Ramakrishnan took the second CT scan of Mr. Newberry's chest on October 23, 2000. Dr. Iosif said the findings were

> consistent with rather profuse small nodular opacities, which coalesce into larger nodules with a preferential subpleural location in the mid lung zones.… The interpreting radiologist, Dr. Ramakrishnan, who is also a B-reader, suggested that the findings could be consistent with conglomerate fibrosis from coal workers' pneumoconiosis in the absence of other occupational exposures. There are radiologic features of coal workers' pneumoconiosis of simple variety with coalescence on plain films but more detailed and accurate CT scan findings that are highly suggestive of conglomerate fibrosis. This is in the absence of any significant respiratory functional impairment.

According to the U.S. Department of Labor standards, Mr. Newberry could be considered totally and irreversibly disabled as a result of his previous coal mine employment given the presence of radiographic features of complicated coal workers' pneumoconiosis with fibrotic conglomeration as seen on CT. It is well known that CT scanning offers a much more accurate and reliable assessment of parenchymal pulmonary abnormalities, such as coal workers' pneumoconiosis/silicosis than plain chest x-rays.

I am submitting not only the x-ray reports, but also the actual plain and CT chest films to be reviewed by other B-readers to determine if they indeed agree with the CT findings of conglomerate fibrosis.

DX 10 at 2-3. (Emphasis in original.)

The Claims Examiner for the Department of Labor wrote to Dr. John Michos to request his opinion whether Mr. Newberry was disabled. DX 16. According to the American Board of Medical Specialties, Dr. Michos is board certified in internal medicine and pulmonary disease. Dr. Michos reviewed the medical records sent by the Claims Examiner and prepared a report dated January 15, 2001. DX 16; DX 17; EX 39. Dr. Michos gave his opinion as follows:

> From the medical evidence presented to me in your letter dated 1/10/01 it is my reasoned medical opinion that Mr. Newberry has evidence of simple CWP based on a 27 year history of CME. As to the issue of a total respiratory disability secondary to simple CWP or complicated CWP, this issue is not resolved at present, given the discrepancy in readings between the two B reader (Dr. Navani and Dr. Ramakrishnan). Additionally, although the miner has evidence of nocturnal hypoxemia to the high 60's by pulse oximetry, this could be on the basis of sleep apnea, especially given his obesity with normal flows on PFT's and normal resting ABG's on room air.
>
> Thus I would recommend other Board certified, B readers interpret the CT scan … to determine if complicated CWP is truly present and then I would also recommend repeat PFT's with DLCO measurement to ascertain if oxygen transfer is affected from his CWP.

EX 39; DX 17.[4]

The next medical evidence in the record is the report of a follow-up visit to Dr. Iosif on March 12, 2001. Dr. Iosif noted that Mr. Newberry was "doing well except for complaints about

[4] A week later, however, on January 22, 2001, the Claims Examiner for the Department of Labor issued findings on behalf of the District Director denying the claim because Mr. Newberry had failed to establish total disability. DX 19. Just under a year later, Mr. Newberry filed his request for modification, alleging that a mistake of fact had been made based on Dr. Ramakrishnan's interpretation of the October 2000 CT scan as showing complicated pneumoconiosis.

exertional dyspnea, which appear to be more consistent with deconditioning." He had had no recent incidents of angina, and his lungs were clear. Dr. Iosif encouraged Mr. Newberry to join a wellness center or regular exercise program. EX 40.

The next progress record from Dr. Piriz in the record, from a visit made in June 2001, listed Mr. Newberry's problems as coronary artery disease, completely occluded right coronary artery, normal left ventricular size and overall function, progressive dyspnea on exertion, and chronic obstructive pulmonary disease. Mr. Newberry had no particular complaints other than mild shortness of breath which occurred primarily on exertion. Again Dr. Piriz recommended continuing with medical management. EX 52.

During a follow-up visit to Dr. Iosif on July 3, 2001, Mr. Newberry reported no respiratory symptoms. He had begun exercising, and had lost some weight. Dr. Iosif noted that Mr. Newberry's pulmonary auscultation was clear. EX 41.

Progress notes from Mr. Newberry's most recent visit to Dr. McVey, on October 15, 2001, indicate that he went in for flu vaccine. He reported he was following up regularly with Dr. Iosif. He was using oxygen 8-10 hours per day. He said he was breathing okay as long as he did not over-exert himself. Dr. McVey's assessments included COPD. He administered the flu vaccine, and advised Mr. Newberry to return as needed. CX 3.

Dr. Ramakrishnan performed the third CT scan on December 13, 2001. DX 27; CX 2. The results are reported above.

Dr. Iosif prepared a letter in support of Mr. Newberry's claim dated February 17, 2002. DX 27; CX 2. Dr. Iosif stated that he has been Mr. Newberry's pulmonologist since March, 2000. Dr. Iosif reviewed Mr. Newberry's coal mine employment (30 years), multiple chest x-rays, and the CT scan completed December 13, 2001. Dr. Iosif concluded that in his "opinion, as a Board Certified Pulmonologist, … Mr. Newberry suffers from complicated CWP."

Dr. James Castle examined Mr. Newberry on behalf of the Employer on March 6, 2002. DX 28; DX 31; EX 42. Dr. Castle is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Mr. Newberry worked in the mines for 30 years. He reported a smoking history of 34-51 pack years. The chest examination was normal. Dr. Castle read the x-ray as showing "q/t opacities in all lung zones with a profusion of 2/2." He also observed bilateral subpleural masses, possibly due to large opacities, category B, or to granulomatous disease because of the atypical position of the masses. The pulmonary function test was normal "showing no evidence of obstruction or restriction." Total lung capacity and diffusing capacity were also normal. The resting arterial blood gas study was normal, as was the carboxyhemoglobin level. No exercise study was conducted, as Dr. Piriz had recommended against stress tests due to Mr. Newberry's coronary artery disease. *See* EX 53. Dr. Castle diagnosed coal workers' pneumoconiosis based on x-ray, no respiratory impairment from any cause and coronary artery disease. He also reviewed some of Mr. Newberry's medical records. Based upon his examination and this additional medical data, including the CT scans, Dr. Castle concluded that Mr. Newberry suffers

from simple coal worker's pneumoconiosis but not complicated pneumoconiosis. In his opinion, the large opacities that he originally classified as category B "are most likely related to old granulomatous disease." He went on to state,

> …The presence of a single negative PPD does not totally exclude tuberculosis as a cause for these lesions. Even in the presence of a negative PPD, histoplasmosis is a fungus disease found in Virginia which may produce similar findings. Therefore, after reviewing the CT scan reports, it is my opinion that these changes which I originally classified as category B opacities, may in fact be totally due to granulomatous disease.

Dr. Castle found that Mr. Newberry had no impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines. He said that Category B complicated pneumoconiosis "would be expected show a significant degree of obstruction and restriction on pulmonary function testing." He thought Mr. Newberry's history of nocturnal hypoxemia was due to obesity.

Dr. Iosif wrote a second letter dated January 30, 2003, supporting Mr. Newberry's application for benefits. He again pointed out that he had been Mr. Newberry's pulmonologist since March 2000. He said that PPD skin screening had been "repeatedly negative as recently as February 6, 2002." He had personally reviewed multiple x-rays and CT scans, and had seen readings by others who also found complicated CWP. He went on to state:

> [Mr. Newberry] has no clinical history of serious respiratory infections such as one would expect in a fungal or mycobacterial infectious process that could lead to such extensive pulmonary radiographic abnormalities. Additionally his PPD reactivity has been steadily negative and so has the antibody screening for indication of previous histoplasmosis infection.
>
> I should point out that from a logical clinical standpoint an individual with such extensive sequelar radiographic abnormalities would certainly remember quite vividly having had a respiratory tract infection capable of causing those. This is not the case in Mr. Newberry's medical history. On the other hand we have an established and unquestionable occupational history of coal dust exposure.
>
> It is my opinion, as a Board Certified Pulmonologist, that Mr. Newberry suffers from complicated CWP which according to the Federal standards will render him totally disabled as a result of his occupational lung disease arising from previous coal dust exposure.

CX 3. Dr. Iosif enclosed a copy of the negative test for histoplasmosis with his letter.

Dr. Castle reviewed additional medical data concerning Mr. Newberry and provided a report dated April 4, 2003. EX 44. Dr. Castle stated that after reviewing x-rays taken between 1973 and 1986, "[i]t is not possible for me to determine with a reasonable degree of medical certainty whether or not the above mentioned chest x-rays actually indicated the presence of coal workers' pneumoconiosis because of the significant variability in interpretations." Dr. Castle

also addressed the reason he did not agree with Dr. Iosif's diagnosis of complicated pneumoconiosis. Dr. Castle based his opinion that Mr. Newberry suffered from granulomatous disease on his review of CT scan reports. The CT scan dated March 21, 2000, did not include findings indicative of complicated coal workers' pneumoconiosis. Of two interpretations of the CT scan dated October 23, 2000, one found simple CWP with no large opacities, and the other gave alternative diagnoses of complicated CWP or changes due to asbestos exposure. Finally, Dr. Castle disagreed with Dr. Alexander's interpretation that the December 13, 2001, CT scan showed complicated pneumoconiosis, based on descriptions of the usual findings in scientific literature, and the presence of calcifications within the liver, indicating the presence of granulomatous disease from either tuberculosis, or a fungal disease such as histoplasmosis. He said that complicated coal workers' pneumoconiosis "is frequently associated with significant respiratory impairment." Dr. Castle concluded that it was his opinion with a reasonable degree of medical certainty that Mr. Newberry does not suffer from complicated CWP, but does suffer from simple CWP and granulomatous disease. Finally, Dr. Castle again concluded that Mr. Newberry is not permanently and totally disabled as a result of the simple CWP.

Complicated Pneumoconiosis

In order to establish the right to benefits, a living miner must establish that he is totally disabled due to pneumoconiosis arising out of his coal mine employment. All three pulmonologists consulted by the parties (Dr. Iosif, Dr. Michos and Dr. Castle[5]) agreed that Mr. Newberry has coal workers' pneumoconiosis. This is consistent with the weight of the x-ray evidence since October 2000, as well as the CT scans, and I reject the contrary opinions from Drs. Wheeler, Scott and Fino, all of whom read the x-rays as negative. The pulmonary function tests and arterial blood gas studies were normal, however, and thus do not meet the standards for disability. Nonetheless, the Act and the regulations provide an irrebuttable presumption of total disability due to pneumoconiosis for a miner diagnosed with complicated pneumoconiosis. 30 U.S.C. § 921(c); 20 CFR § 718.304 (2005). Dr. Iosif is of the opinion that Mr. Newberry has complicated pneumoconiosis. Dr. Castle disagrees. Dr. Michos did not offer an opinion on this point.

Pursuant to Section 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304 (b) by biopsy or autopsy or under Section 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under Section 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth Circuit has held that "…even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B)

[5] Dr. Fino is also a pulmonologist, but was only consulted for the limited purpose of x-ray interpretations.

[biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F. 3d 250, 256 (4th Cir. 2000).

Turning first to the x-rays, the first to have been read as showing category B opacities was the one taken November 13, 2001. The radiologist who took the x-ray, Dr. Fleming, whose qualifications are unknown, observed that pneumoconiosis was more pronounced than on an earlier x-ray, but did not classify it. Dr. Alexander, a board certified radiologist and B reader, read it as showing small opacities, profusion 2/2, and large opacities, category B. Dr. Navani, also dually qualified, identified only small opacities, as he did on a subsequent x-ray taken December 13, 2001. All three readings of the most recent x-ray taken March 6, 2002, however, were classified to contain B opacities by two dually qualified radiologists, Drs. Alexander and DePonte, and by Dr. Castle, a B reader. Dr. Castle stated in his report, however, that the B opacities he had identified represented granulomatous disease, rather than complicated pneumoconiosis. Nonetheless, I find that as all the B readers observed size B opacities, the March 6, 2002, x-ray, in particular, tends to support a finding of complicated pneumoconiosis.

As to the CT scans taken by Dr. Ramakrishnan, who is a board certified radiologist and B reader, he himself did not classify the larger nodules, but said although "atypical," they "may" represent coalescent nodules of pneumoconiosis, or, as a differential diagnosis, he suggested the possibility of asbestos exposure. There is no evidence, however, that Mr. Newberry was exposed to asbestos. Dr. Iosif thought the second CT scan suggested complicated pneumoconiosis, and forwarded the film to the Department of Labor for additional reading. Two dually qualified radiologists, Drs. Alexander and Dr. DePonte, both diagnosed complicated pneumoconiosis based on the most recent CT scan, as did Dr. Iosif. Only Dr. Castle excluded complicated pneumoconiosis as a diagnosis. Based on the greater number of well-qualified readers who diagnosed it, I find that the CT scan evidence also tends to support a finding of complicated pneumoconiosis.

Finally, I must consider Dr. Iosif's opinion in conjunction with Dr. Castle's. Both Dr. Iosif and Dr. Castle are highly qualified pulmonologists. Both had the opportunity to examine Mr. Newberry, and access to his medical history. Both opinions are well documented and reasoned. In the final analysis, I find that Dr. Iosif's opinion, as Mr. Newberry's treating physician, should be given controlling weight. Dr. Iosif saw Mr. Newberry on a regular basis and was primarily responsible for his ongoing care. Although Dr. Castle suggested tuberculosis and histoplasmosis as alternative causes for the large opacities, Dr. Iosif ruled out those causes by repeated testing. Dr. Castle's comment that complicated pneumoconiosis is "frequently associated with significant respiratory impairment" does not exclude the possibility that Mr. Newberry has the disease despite the normal results of his pulmonary function and arterial blood gas studies. Dr. Iosif's opinion is supported by the x-ray and CT scan evidence in the record, and thus is in better accord with the weight of the objective evidence, and the evidence as a whole.

I find that Mr. Newberry is totally disabled due to pneumoconiosis based on the irrebuttable presumption applicable once a miner has been diagnosed with complicated pneumoconiosis.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR § 725.503(b) (2005). The claim in this case was filed in September 2000. My finding that the Claimant is totally disabled rests upon the diagnosis of complicated pneumoconiosis. The date of entitlement, then, must be determined based on when Mr. Newberry's condition progressed from simple to complicated pneumoconiosis.

Dr. Iosif observed some coalescence of nodules on the March 2000 CT scan, but he did not diagnose complicated pneumoconiosis at that time. No readers observed large opacities on the October 2000 x-ray. Moreover, although Dr. Iosif interpreted the October 2000 CT scan as "highly suggestive of conglomerate fibrosis," he did not classify any large opacity by size, and referred the x-ray and CT films to the Department of Labor to be reviewed for confirmation. Dr. Michos also recommended that the films be reviewed by other, board certified B readers. The presence of complicated pneumoconiosis was not confirmed until B opacities were identified in the November 13, 2001, x-ray, and December 13, 2001, CT scan.

I find that the opacities observed by Dr. Iosif on the October 2000 CT scan, which were visible as category B opacities on x-ray by November 2001, and on CT scan by December 2001, would have been large enough to meet the standard for disability, i.e., category A opacities, sometime between October 2000 and November 2001. Given the rapid increase in profusion and coalescence of nodules after October 2000, I conclude that three months is a reasonable period to project sufficient growth of the large opacities to meet the standard for total disability. Claimant is therefore entitled to benefits commencing in January 2001.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that he has complicated coal workers' pneumoconiosis. It follows that he is totally disabled due to pneumoconiosis arising from his coal mine employment within the meaning of the Act and the regulations. He is therefore entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The regulations address non-attorney representatives' fees at 20 CFR §§ 725.362, 365 and 366 (2005). The Claimant's representative has not yet filed an application for fees. The Claimant's representative is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties (including the Claimant) have ten days following

service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Roger Newberry, September 22, 2000 is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).